Preventive Services

Reimbursement Policy ID: RPC.0088.5420

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses the health plan reimbursement criteria for preventive care services.

Exceptions

N/A

Reimbursement Guidelines

Preventive Medicine Evaluation and Management (E/M)
The preventive medicine evaluation and management (E/M) services (CPT codes 99381-99397; HCPCS codes G0438-G0439) include a history and examination appropriate for the patient's age and gender, provider recommendations and guidance related to personal risk factors, laboratory and other diagnostic procedures

ordered, and treatment of minor problems or complaints that do not require additional work by the provider. Given the comprehensive nature of preventive medicine E/M services, few additional services are eligible for reimbursement to the same provider when performed on the same day for the same member.

Significant Separately Identifiable E/M
If a preexisting condition or abnormality that requires additional work beyond the components of a preventive visit is addressed during a preventive medicine service, reimbursement may be available for the appropriate problem-oriented E/M code if it is appended with Modifier 25 and reported on the same claim. The health plan will reimburse the amount allowed for a second E/M code if it is appended with Modifier 25, associated to a problem-oriented diagnosis, and supported in the medical record.

Vaccine Administration Services
Vaccines for enrollees aged 18 years and younger should be obtained through the Vaccines for Children Program (VFC). The health plan reimburses vaccinations administered during a preventive medicine visit at the allowable amount. Vaccines obtained through the Vaccines for Children (VFC) program are not eligible for reimbursement by the health plan but providers are reimbursed for the vaccine administration by billing with the appropriate procedure codes and modifier. Providers are expected to plan for a sufficient supply of vaccines and are required to report the use of VFC immunizations through the District of Columbia Immunization Registry.

Visual Function and Acuity Screening Services
Visual function and acuity screening services (99172, 99173, 0333T) provided to the same member by the same provider on the same date of service as a preventive medicine E/M will be considered eligible for separate reimbursement.

For questions regarding vision services, enrollees and providers may contact:

- Enrollee Services Medicaid – (202) 408-4720

Prolonged Services
Prolonged services codes (CPT 99415-99418) are intended for use with problem-oriented E/M services and are not eligible for separate reimbursement by The health plan when reported by the same provider on the same day as a preventive medicine E/M.

Preventive Care for Adults
The health plan considers age- and gender-appropriate preventive care services included under the District of Columbia managed care program to be eligible for reimbursement. Examples *may* include some or all of the following, but reimbursement may only be made if the service is covered under the District of Columbia Medicaid program:

- Abdominal Aortic Aneurysm (AAA) screening;
- Bone density measurement;
- Cardiovascular disease screening;
- Screenings for breast, lung, cervix, prostate, and colorectal cancers;
- Screening for sexually transmitted infections (STIs);
- Glaucoma screening;
- Preventive gynecological care (e.g., pelvic exams, clinical breast exam, cervical cancer screening, Pap tests);
- Screening for hepatitis B, hepatitis C, tuberculosis;
- HIV screening and pre-exposure prophylaxis (PrEP);
- Individual risk factor assessments (e.g., cardiovascular disease, depression, diabetes, substance use disorders, depression, etc.);
- Vaccinations and vaccine administration.

Preventive Care for Children
The health plan provides comprehensive preventive care for children. Our Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of enrollees from birth to age 21 by increasing adherence to Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines (called HealthCheck in the District of Columbia) through identification of growth and development needs and coordination of appropriate health care services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under up to 21 (twenty-one) years of age who are enrolled in Medicaid. This program ensures that children and adolescents receive appropriate preventive, hearing, vision, dental, behavioral health, developmental, laboratory, and specialty services. Refer to District of Columbia state guidelines for applicable procedure codes and requirements.

All the health plan PCPs are responsible to provide HealthCheck services to enrollees from birth to age 21, according to the D.C. Medicaid HealthCheck Periodicity Schedule and the D.C. Medicaid Dental Periodicity Schedule or upon request at other times in order to determine the existence of a physical or mental condition.

For the initial examination and assessment of a child, PCPs are required to perform the relevant HealthCheck screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs. The PCP must report the determination to the health plan Rapid Response team at 1-877-759-6224

Periodic assessments must consist of the following components:

- Comprehensive health and developmental history (including physical and mental health development).
- An unclothed comprehensive health exam.
- Appropriate immunizations based on the recommendations of the CDC's Advisory Committee on
- Immunization Practices (ACIP).
- Laboratory testing (including blood lead testing for children prior to the age of 2 years and up to the age of six).
- Health education (including anticipatory guidance).
- Dental, vision and/or hearing screenings (in accordance with the District of Columbia HealthCheck periodicity guidelines and at other intervals as needed to identify suspected illness or condition).
- Diagnosis and treatment.
- Referral and follow-up as appropriate.

The health plan Health Check providers (PCPs) are expected to provide written and verbal explanation of EPSDT services to Plan enrollees including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris teenagers. This explanation of EPSDT services should occur on the enrollee's first visit and quarterly thereafter and must include distribution of appropriate EPSDT educational tools and materials.

Screening Timeframes
HealthCheck providers (PCPs) are contractually obligated to provide HealthCheck screenings within 30 days of the scheduled due date for children under the age of two years and within 60 days of the scheduled due date for children aged two years and older.

Initial HealthCheck screenings must be offered to new enrollees within 60 days of becoming a The health plan enrollee, or at an earlier time if needed to comply with the periodicity schedule. At the latest, the initial HealthCheck screening must be completed within three months of the enrollee's enrollment date with the health plan. Periodic HealthCheck screenings must occur within 30 days of the request.

Definitions

Evaluation and Management (E/M)
Evaluation and management (E/M) codes represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health. Procedures such as diagnostic tests, radiology, surgery and other particular therapies are not considered evaluation and management services.

Modifier 25 – Significant, Separately Identifiable E/M
Modifier 25 indicates a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Preventive Services
Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)
VI. Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care.

Attachments

N/A

Associated Policies

RPC.0009.5420 Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)
RPC.0021.5420 New Patient Visit
RPC.0065.5420 Vaccine
RPC.0066.5420 Evaluation and Management
RPC.0094.5420 Early and Periodic Screening, Diagnostics and Treatment (EPSDT)

Policy History

09/2026	Reimbursement Policy Committee Approval
07/2026	Biennial review • Removed Alliance language • Revised preamble • Removed the next review date • Replaced the plan name with "the health plan"
12/2025	Reimbursement Policy Committee Approval